

Kenya National Health Accounts 2002: Estimating Expenditures on General Health and HIV/AIDS Care

With over half the population considered poor, it is alarming that 51 percent of all health care expenditures in Kenya are borne by households. HIV-infected persons pay nearly half of HIV/AIDS treatment costs, and donors fund more than half of Kenya's HIV/AIDS expenditures overall. Such National Health Accounts findings reveal a need to address sustainability and equity of health care resource allocation.

The government of Kenya (GoK) faces the dilemma of combating a growing burden of disease, regulating quality, and improving equity in health care distribution within the context of declining public financing that is forcing rationalization of health service delivery. To help resolve the dilemma, Kenyan policymakers need a comprehensive understanding of the organization and financing of the country's health care system, including the expenditures on health care made by donors, public sector entities, and the private sector, particularly households. One tool that the government is using to understand health care expenditures is National Health Accounts (NHA), an internationally accepted framework for tracking the expenditures from their sources to their end uses.

Background

Kenya conducted its first NHA estimation in 1998, using 1994 data. Prior to this, key policymakers assumed that the GoK was the major financier of health care services. However, the 1998 NHA revealed that more than 53 percent of health care spending actually came from households, with the Kenyan government financing only 19 percent. The high household expenditure finding was particularly alarming and spurred Kenyan policymakers to further investigate health care equity issues. Consequently, the government commissioned a series of in-depth studies on the burden of health

financing in the country. The GoK also undertook a second NHA exercise, using expenditures from fiscal year (FY) 2002.¹ This NHA round was more ambitious than that done in 1998; it included detailed data on household spending gleaned from a household health care utilization and expenditure survey² and extended the NHA framework to estimate expenditures on HIV/AIDS health care, a pressing national policy issue. Its findings should be of use to all health care stakeholders – public, private, and donor – who seek to efficiently and equitably distribute their health care resources.

This brief summarizes salient findings from Kenya's NHA 2002 report.³

Investment in Health Care

In terms of the overall health resource envelope, Kenya spends 5.1 percent of its gross domestic product (GDP) on health (Table 1). This is comparable to other countries in sub-Saharan Africa, which average 5.7 percent, but well below the high-income OECD countries' average of 9.8 percent. Per capita spending is Kenyan shilling (KShs) 1,506

¹ Specifically, 1 July 2001–30 June 2002

² Ministry of Health. March 2005. *Household Health Expenditure and Utilisation Report 2003*. Nairobi

³ Ministry of Health. March 2005. *Kenya National Health Accounts 2001/02*. Nairobi

Table 1. Profile of Overall Health Spending in Kenya (FY 2002)

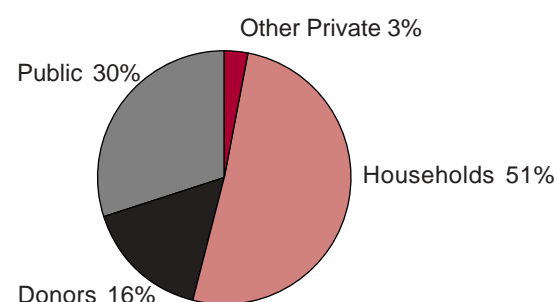
Indicator	Value
Total Health Expenditure (THE) (million)	KSh 46,989 (US\$ 598)
As % of GDP	5.1
Health expenditure per capita (KSh)	1,506
Health expenditure per capita (US\$)	19.2
Public health expenditure as % of total government expenditure	8
Sources of funds (as % of THE)	
Public	30%
Private	54%
Donors	16%
Household expenditure	
Total household expenditure as % of THE	51%
Out-of-pocket expenditure as % of THE	45%
OOP expenditure per capita	KSh 674 (US\$ 8.58)
Providers (% of THE)	
Public health provider expenditure	60%
Private health provider expenditure	39%
Other (not-specified-by-kind)	1%
Functions (% of THE)	
Outpatient curative care	45.2%
Inpatient curative care	32.1%
Prevention & public health services	9.1%
Pharmaceuticals	7.4%
Health administration	5.0%
Others (e.g., capital formation for health care institutions)	1.3%

(US\$19), which translates to a 10 percent decline from spending level in 1998 (Ksh 1,170; US\$21).

The NHA household health care utilization and expenditure survey found that households in the poorer income quintiles use less health care than do households in the richest quintile – more than a third of the poor who were ill did not seek care compared to only 15 percent of the rich. This suggests that inability to pay is contributing to lower utilization rates by the poor. The FY 2002 NHA exercise found that more than half of health care financing (51 percent) comes from households (Figure 1). This is significant considering that

56 percent of the population is poor, and, like the survey findings, it raises concerns about financial accessibility to health care by that segment of the population. Although public facilities receive 60 percent of all spending on health care, public sources of funds account for only 30 percent of total health expenditures, or approximately 8 percent of all spending by the government. This share of public spending on health care falls appreciably short of the 15-percent goal outlined in the Abuja Declaration.⁴ The other major financiers of health care in Kenya were the donor community, which contribute 16 percent of total health expenditures, and employers, which contribute 3 percent.

Figure 1: Who Pays for Health Care in Kenya?



With these findings, NHA identified the magnitude of issues facing policymakers. NHA estimations now are being used to explore alternative and sustainable financing mechanisms to encourage equity in financial access to care. Currently, the government is using NHA findings to inform allocative formulas for health care resources in its design of a social health insurance scheme and community-based health insurance programs.

Investment in HIV/AIDS Care

HIV has had considerable impact on the Kenyan population, accounting in large part for a 15-year drop in life expectancy. Indeed, from 1990 to 2001, the life expectancy fell from 62 years to 47 years. Given this catastrophic impact and the current adult prevalence rate of 6.7 percent, the GoK is committed to stemming the spread of the disease. It therefore implemented the NHA HIV/AIDS subanalysis, to obtain key

⁴ Adopted by African leaders at the 24-27 April 2001 summit in Abuja, Nigeria.

HIV/AIDS health-related expenditure data to guide its strategic planning of HIV/AIDS health care and to establish a baseline dataset that will help analyze the impact of allocations of recent large-scale donor commitments (the Global Fund to Fight AIDS, Tuberculosis and Malaria, the President's Emergency Program for AIDS Relief [PEPFAR], and others).

Table 2. Profile of HIV/AIDS Spending in Kenya (FY 2002)

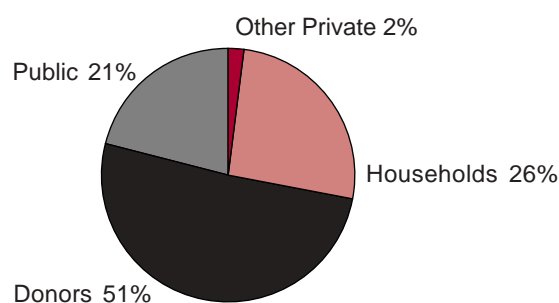
Indicator	Value
Prevalence rate (adults) 2003	6.7%*
Total Health Expenditure (THE) on HIV/AIDS (million)	KSh 8,170 (US\$ 103.9)
Percent of general THE spent on HIV/AIDS	17.4%
Total HIV/AIDS health expenditures as % of GDP (at current market prices)	1%
Distribution of sources of HIV/AIDS funds	
Public (health expenditures as % of THE for HIV/AIDS)	21%
Private	28%
Donor	51%
Household expenditure	
As % of THE for general health care	4.6%
As % of THE for HIV/AIDS	26%
Out-of-pocket payments as % of THE for HIV/AIDS	21%
Uses of funds by provider type as % of THE for HIV/AIDS	
Public	78.0%
Private for-profit	10.3%
Private not-for-profit	10.8%
Other providers (not-specified-by-kind)	0.9%
Uses of funds by functions as % of THE for HIV/AIDS	
Expenditure on curative care services (inpatient and outpatient)	44.2%
Expenditure on preventive and public health services	47.1%
Expenditures on pharmaceuticals and other nondurables	4.9%
Expenditures on other services	3.8%

*Central Bureau of Statistics (Government of Kenya), Ministry of Health (GoK), Kenya Medical Research Institute, U.S. Centers for Disease Control and Prevention, MEASURE DHS+ ORC Macro. December 2003. *Kenya Demographic and Health Survey, 2003, Preliminary Report*. Nairobi.

Findings from the NHA HIV/AIDS subanalysis show that more than 17 percent of total health financing goes to HIV/AIDS treatment and other health services (equivalent to 1 percent of the GDP). This equates to KShs 8,314 or US\$ \$105.80 per person living with HIV/AIDS (PLWHA). A much larger resource envelope is needed to scale up anti-retroviral therapies (ARTs), estimated to cost \$480 per PLWHA.

In contrast to the financing patterns for overall health care, HIV/AIDS financing comes largely from the donor community; whereas donors finance 16 percent of health care overall, they finance more than half (51 percent) of all HIV expenditures. Other financing sources are households (26 percent), the government (21 percent), and "other" (1 percent) (Figure 2).

Figure 2: Who Pays for HIV/AIDS Care in Kenya?

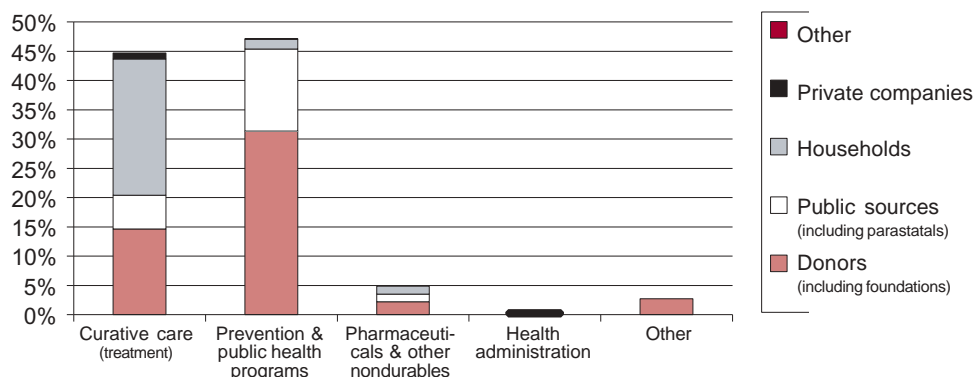


These findings raise two concerns:

- ▲ Are such spending proportions sustainable given the long-term challenges posed by HIV/AIDS (and keeping in mind that the findings represent donor expenditures prior to the influx of large-scale funds from the Global Fund, PEPFAR, and others)?
- ▲ Has donor spending on HIV/AIDS shifted funds from other priority programs such as malaria, another major cause of morbidity and mortality in the country?

Although financing by households (PLWHA) does not contribute the largest share of the total health expenditures, this share is by no means insignificant. PLWHA in Kenya spend approximately three times more on health care than does the general population. While PLWHA account for approximately 3 percent of the total population, they account for 8 percent of total out-of-pocket spending on health – again raising concerns about who bears the absolute financial burden of health care and about equity in proportioning that burden.

Figure 3: What Types of HIV/AIDS Services Are Being Funded and by Whom?



Further NHA investigation into out-of-pocket spending reveals various types of inequities: not only do men infected with HIV use more health services per capita than do infected women, they also spend 1.6 times as much as infected females. This pattern is contrary to that seen among men and women in the general Kenyan population, where women tend to use more services than men. Also, PLWHA living in urban areas spend nearly 1.3 times per capita as those living in rural areas.

Figure 3 describes how HIV/AIDS monies are being spent. Prevention absorbs the greatest proportion of HIV/AIDS expenditures, followed by care and treatment. Households' HIV/AIDS spending accounts for close to half of all curative (treatment) expenditures. Donor financing goes mainly to HIV/AIDS prevention and public health programs via the Ministry of Health, which manages the disbursement process.

Next Steps

In summary, the general and HIV/AIDS NHA findings reveal a need to address the issue of equity in health care resource allocation. To this end, the GoK is using NHA findings to inform its resource allocation formulas for the development of the social health insurance plan and community-based health insurance schemes, and the distribution of Ministry of Health funds among public facilities. The ministry also plans to use the findings to carry out further analysis into the efficiency of hospital-based service delivery by more closely monitoring the consumption of resources against production of outputs.

The GoK is committed to institutionalizing the NHA process, so that estimates like those presented here can be produced on a regular basis and used for evidence-based policymaking. Subsequent NHAs will aid in establishing trend data to monitor the effects of major health policy interventions, such as decentralization of the health sector and disbursement of large amounts of HIV/AIDS funds during the scale-up of ART delivery.



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